



Pre-Transplant Essential Data

<p>CIBMTR Use Only Sequence Number:</p> <p>Date Received:</p>

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<p>Center Identification</p> <p>CIBMTR Center Number: _____</p> <p>EBMT Code (CIC): _____</p> <p>Recipient Identification</p> <p>CIBMTR Research ID (CRID): _____</p> <p>Event date: __ __ / __ __ / __ __ YYYY MM DD</p>

Recipient Information

1. Date of birth: __ __ / __ __ / __ __
YYYY MM DD

2. Sex Male Female

3. Ethnicity Hispanic or Latino Not Hispanic or Latino Not applicable (not a resident of the USA) Unknown

4. Race (check all that apply)

- White →
- Black or African American →
- Asian →
- American Indian or Alaska Native →
- Native Hawaiian or Other Pacific Islander →
- Not reported - **Go to question 6**
- Unknown - **Go to question 6**

5. Race detail (check all that apply)

- Eastern European
- Mediterranean
- Middle Eastern
- North Coast of Africa
- North American
- Northern European
- Western European
- White Caribbean
- White South or Central American
- Other White
- African
- African American
- Black Caribbean
- Black South or Central American
- Other Black
- Alaskan Native or Aleut
- North American Indian
- American Indian, South or Central America
- Caribbean Indian
- South Asian
- Filipino (Pilipino)
- Japanese
- Korean
- Chinese
- Vietnamese
- Other Southeast Asian
- Guamanian
- Hawaiian
- Samoan
- Other Pacific Islander
- Unknown

6. Country of primary residence

- | | | |
|---|--|--|
| <input type="checkbox"/> Afghanistan | <input type="checkbox"/> Chad | <input type="checkbox"/> Grenada |
| <input type="checkbox"/> Aland Islands | <input type="checkbox"/> Chile | <input type="checkbox"/> Guadeloupe |
| <input type="checkbox"/> Albania | <input type="checkbox"/> China | <input type="checkbox"/> Guam |
| <input type="checkbox"/> Algeria | <input type="checkbox"/> Christmas Island | <input type="checkbox"/> Guatemala |
| <input type="checkbox"/> American Samoa | <input type="checkbox"/> Cocos (Keeling) Islands | <input type="checkbox"/> Guernsey |
| <input type="checkbox"/> Andorra | <input type="checkbox"/> Colombia | <input type="checkbox"/> Guinea |
| <input type="checkbox"/> Angola | <input type="checkbox"/> Comoros | <input type="checkbox"/> Guinea-Bissau |
| <input type="checkbox"/> Anguilla | <input type="checkbox"/> Congo, Democratic Republic of the | <input type="checkbox"/> Guyana |
| <input type="checkbox"/> Antarctica | <input type="checkbox"/> Congo, Republic of the | <input type="checkbox"/> Haiti |
| <input type="checkbox"/> Antigua and Barbuda | <input type="checkbox"/> Cook Islands | <input type="checkbox"/> Heard Island and McDonald Islands |
| <input type="checkbox"/> Argentina | <input type="checkbox"/> Costa Rica | <input type="checkbox"/> Holy See |
| <input type="checkbox"/> Armenia | <input type="checkbox"/> Cote d'Ivoire | <input type="checkbox"/> Honduras |
| <input type="checkbox"/> Aruba | <input type="checkbox"/> Croatia | <input type="checkbox"/> Hong Kong |
| <input type="checkbox"/> Australia | <input type="checkbox"/> Cuba | <input type="checkbox"/> Hungary |
| <input type="checkbox"/> Austria | <input type="checkbox"/> Curacao | <input type="checkbox"/> Iceland |
| <input type="checkbox"/> Azerbaijan | <input type="checkbox"/> Cyprus | <input type="checkbox"/> India |
| <input type="checkbox"/> Bahamas | <input type="checkbox"/> Czech Republic | <input type="checkbox"/> Indonesia |
| <input type="checkbox"/> Bahrain | <input type="checkbox"/> Denmark | <input type="checkbox"/> Iran |
| <input type="checkbox"/> Bangladesh | <input type="checkbox"/> Djibouti | <input type="checkbox"/> Iraq |
| <input type="checkbox"/> Barbados | <input type="checkbox"/> Dominica | <input type="checkbox"/> Ireland |
| <input type="checkbox"/> Belarus | <input type="checkbox"/> Dominican Republic | <input type="checkbox"/> Isle of Man |
| <input type="checkbox"/> Belgium | <input type="checkbox"/> Ecuador | <input type="checkbox"/> Israel |
| <input type="checkbox"/> Belize | <input type="checkbox"/> Egypt | <input type="checkbox"/> Italy |
| <input type="checkbox"/> Benin | <input type="checkbox"/> El Salvador | <input type="checkbox"/> Jamaica |
| <input type="checkbox"/> Bermuda | <input type="checkbox"/> Equatorial Guinea | <input type="checkbox"/> Japan |
| <input type="checkbox"/> Bhutan | <input type="checkbox"/> Eritrea | <input type="checkbox"/> Jersey |
| <input type="checkbox"/> Bolivia | <input type="checkbox"/> Estonia | <input type="checkbox"/> Jordan |
| <input type="checkbox"/> Bonaire, Sint Eustatius and Saba | <input type="checkbox"/> Ethiopia | <input type="checkbox"/> Kazakhstan |
| <input type="checkbox"/> Bosnia and Herzegovina | <input type="checkbox"/> Falkland Islands | <input type="checkbox"/> Kenya |
| <input type="checkbox"/> Botswana | <input type="checkbox"/> Faroe Islands | <input type="checkbox"/> Kiribati |
| <input type="checkbox"/> Bouvet Island | <input type="checkbox"/> Fiji | <input type="checkbox"/> Kuwait |
| <input type="checkbox"/> Brazil - go to question 7 | <input type="checkbox"/> Finland | <input type="checkbox"/> Kyrgyzstan |
| <input type="checkbox"/> British Indian Ocean Territory | <input type="checkbox"/> France | <input type="checkbox"/> Laos |
| <input type="checkbox"/> British Virgin Islands | <input type="checkbox"/> French Guiana | <input type="checkbox"/> Latvia |
| <input type="checkbox"/> Brunei Darussalam | <input type="checkbox"/> French Polynesia | <input type="checkbox"/> Lebanon |
| <input type="checkbox"/> Bulgaria | <input type="checkbox"/> French Southern Territories | <input type="checkbox"/> Lesotho |
| <input type="checkbox"/> Burkina Faso | <input type="checkbox"/> Gabon | <input type="checkbox"/> Liberia |
| <input type="checkbox"/> Burundi | <input type="checkbox"/> Gambia | <input type="checkbox"/> Libya |
| <input type="checkbox"/> Cambodia | <input type="checkbox"/> Georgia | <input type="checkbox"/> Liechtenstein |
| <input type="checkbox"/> Cameroon | <input type="checkbox"/> Germany | <input type="checkbox"/> Lithuania |
| <input type="checkbox"/> Canada - go to question 8 | <input type="checkbox"/> Ghana | <input type="checkbox"/> Luxembourg |
| <input type="checkbox"/> Cape Verde | <input type="checkbox"/> Gibraltar | <input type="checkbox"/> Macau |
| <input type="checkbox"/> Cayman Islands | <input type="checkbox"/> Greece | <input type="checkbox"/> Macedonia |
| <input type="checkbox"/> Central African Republic | <input type="checkbox"/> Greenland | <input type="checkbox"/> Madagascar |

- | | | |
|---|--|---|
| <input type="checkbox"/> Malawi | <input type="checkbox"/> Papua New Guinea | <input type="checkbox"/> Sri Lanka |
| <input type="checkbox"/> Malaysia | <input type="checkbox"/> Paraguay | <input type="checkbox"/> Sudan |
| <input type="checkbox"/> Maldives | <input type="checkbox"/> Peru | <input type="checkbox"/> Suriname |
| <input type="checkbox"/> Mali | <input type="checkbox"/> Philippines | <input type="checkbox"/> Svalbard and Jan Mayen |
| <input type="checkbox"/> Malta | <input type="checkbox"/> Pitcairn Islands | <input type="checkbox"/> Swaziland |
| <input type="checkbox"/> Marshall Islands | <input type="checkbox"/> Poland | <input type="checkbox"/> Sweden |
| <input type="checkbox"/> Martinique | <input type="checkbox"/> Portugal | <input type="checkbox"/> Switzerland |
| <input type="checkbox"/> Mauritania | <input type="checkbox"/> Puerto Rico | <input type="checkbox"/> Syria |
| <input type="checkbox"/> Mauritius | <input type="checkbox"/> Qatar | <input type="checkbox"/> Taiwan |
| <input type="checkbox"/> Mayotte | <input type="checkbox"/> Reunion | <input type="checkbox"/> Tajikistan |
| <input type="checkbox"/> Mexico | <input type="checkbox"/> Romania | <input type="checkbox"/> Tanzania |
| <input type="checkbox"/> Micronesia | <input type="checkbox"/> Russia | <input type="checkbox"/> Thailand |
| <input type="checkbox"/> Moldova | <input type="checkbox"/> Rwanda | <input type="checkbox"/> Timor-Leste |
| <input type="checkbox"/> Monaco | <input type="checkbox"/> Saint Barthelemy | <input type="checkbox"/> Togo |
| <input type="checkbox"/> Mongolia | <input type="checkbox"/> Saint Helena | <input type="checkbox"/> Tokelau |
| <input type="checkbox"/> Montenegro | <input type="checkbox"/> Saint Kitts and Nevis | <input type="checkbox"/> Tonga |
| <input type="checkbox"/> Montserrat | <input type="checkbox"/> Saint Lucia | <input type="checkbox"/> Trinidad and Tobago |
| <input type="checkbox"/> Morocco | <input type="checkbox"/> Saint Martin, French | <input type="checkbox"/> Tunisia |
| <input type="checkbox"/> Mozambique | <input type="checkbox"/> Saint Pierre and Miquelon | <input type="checkbox"/> Turkey |
| <input type="checkbox"/> Myanmar | <input type="checkbox"/> Saint Vincent and the Grenadines | <input type="checkbox"/> Turkmenistan |
| <input type="checkbox"/> Namibia | <input type="checkbox"/> Samoa | <input type="checkbox"/> Turks and Caicos Islands |
| <input type="checkbox"/> Nauru | <input type="checkbox"/> San Marino | <input type="checkbox"/> Tuvalu |
| <input type="checkbox"/> Nepal | <input type="checkbox"/> Sao Tome and Principe | <input type="checkbox"/> Uganda |
| <input type="checkbox"/> Netherlands | <input type="checkbox"/> Saudi Arabia | <input type="checkbox"/> Ukraine |
| <input type="checkbox"/> Netherlands Antilles | <input type="checkbox"/> Senegal | <input type="checkbox"/> United Arab Emirates |
| <input type="checkbox"/> New Caledonia | <input type="checkbox"/> Serbia | <input type="checkbox"/> United Kingdom (England, Wales, Scotland,
Northern Ireland) |
| <input type="checkbox"/> New Zealand | <input type="checkbox"/> Seychelles | <input type="checkbox"/> United States - go to question 9 |
| <input type="checkbox"/> Nicaragua | <input type="checkbox"/> Sierra Leone | <input type="checkbox"/> United States Minor Outlying Islands |
| <input type="checkbox"/> Niger | <input type="checkbox"/> Singapore | <input type="checkbox"/> United States Virgin Islands |
| <input type="checkbox"/> Nigeria | <input type="checkbox"/> Sint Maarten, Dutch | <input type="checkbox"/> Uruguay |
| <input type="checkbox"/> Niue | <input type="checkbox"/> Slovak Republic | <input type="checkbox"/> Uzbekistan |
| <input type="checkbox"/> Norfolk Island | <input type="checkbox"/> Slovenia | <input type="checkbox"/> Vanuatu |
| <input type="checkbox"/> North Korea | <input type="checkbox"/> Solomon Islands | <input type="checkbox"/> Venezuela |
| <input type="checkbox"/> Northern Mariana Islands | <input type="checkbox"/> Somalia | <input type="checkbox"/> Vietnam |
| <input type="checkbox"/> Norway | <input type="checkbox"/> South Africa | <input type="checkbox"/> Wallis and Futuna Islands |
| <input type="checkbox"/> Oman | <input type="checkbox"/> South Georgia and the South Sandwich
Islands | <input type="checkbox"/> Western Sahara |
| <input type="checkbox"/> Pakistan | <input type="checkbox"/> South Korea | <input type="checkbox"/> Yemen |
| <input type="checkbox"/> Palau | <input type="checkbox"/> South Sudan | <input type="checkbox"/> Zambia |
| <input type="checkbox"/> Palestine, State of | <input type="checkbox"/> Spain | <input type="checkbox"/> Zimbabwe |
| <input type="checkbox"/> Panama | | |

7. State of residence of recipient (for residents of Brazil) - **Go to question 10**

- | | | |
|---|---|--|
| <input type="checkbox"/> Acre | <input type="checkbox"/> Maranhão | <input type="checkbox"/> Rio de Janeiro |
| <input type="checkbox"/> Alagoas | <input type="checkbox"/> Mato Grosso | <input type="checkbox"/> Rio Grande do Norte |
| <input type="checkbox"/> Amapá | <input type="checkbox"/> Mato Grosso do Sul | <input type="checkbox"/> Rio Grande do Sul |
| <input type="checkbox"/> Amazonas | <input type="checkbox"/> Minas Gerais | <input type="checkbox"/> Rondônia |
| <input type="checkbox"/> Bahia | <input type="checkbox"/> Pará | <input type="checkbox"/> Roraima |
| <input type="checkbox"/> Ceará | <input type="checkbox"/> Paraná | <input type="checkbox"/> Santa Catarina |
| <input type="checkbox"/> Distrito Federal | <input type="checkbox"/> Paraíba | <input type="checkbox"/> São Paulo |
| <input type="checkbox"/> Espírito Santo | <input type="checkbox"/> Pernambuco | <input type="checkbox"/> Sergipe |
| <input type="checkbox"/> Goiás | <input type="checkbox"/> Piauí | <input type="checkbox"/> Tocantins |

8. Province or territory of residence of recipient (for residents of Canada) - **Go to question 10**

- | Provinces | Territories |
|--|--|
| <input type="checkbox"/> Alberta | <input type="checkbox"/> Nova Scotia |
| <input type="checkbox"/> British Columbia | <input type="checkbox"/> Northwest Territories |
| <input type="checkbox"/> Quebec | <input type="checkbox"/> Nunavut |
| <input type="checkbox"/> Manitoba | <input type="checkbox"/> Prince Edward Island |
| <input type="checkbox"/> New Brunswick | <input type="checkbox"/> Quebec |
| <input type="checkbox"/> Newfoundland and Labrador | <input type="checkbox"/> Saskatchewan |

9. State of residence of recipient (for residents of USA)

- | | | |
|---|---|---|
| <input type="checkbox"/> Alabama | <input type="checkbox"/> Kentucky | <input type="checkbox"/> North Dakota |
| <input type="checkbox"/> Alaska | <input type="checkbox"/> Louisiana | <input type="checkbox"/> Ohio |
| <input type="checkbox"/> Arizona | <input type="checkbox"/> Maine | <input type="checkbox"/> Oklahoma |
| <input type="checkbox"/> Arkansas | <input type="checkbox"/> Maryland | <input type="checkbox"/> Oregon |
| <input type="checkbox"/> California | <input type="checkbox"/> Massachusetts | <input type="checkbox"/> Pennsylvania |
| <input type="checkbox"/> Colorado | <input type="checkbox"/> Michigan | <input type="checkbox"/> Rhode Island |
| <input type="checkbox"/> Connecticut | <input type="checkbox"/> Minnesota | <input type="checkbox"/> South Carolina |
| <input type="checkbox"/> Delaware | <input type="checkbox"/> Mississippi | <input type="checkbox"/> South Dakota |
| <input type="checkbox"/> District of Columbia | <input type="checkbox"/> Missouri | <input type="checkbox"/> Tennessee |
| <input type="checkbox"/> Florida | <input type="checkbox"/> Montana | <input type="checkbox"/> Texas |
| <input type="checkbox"/> Georgia | <input type="checkbox"/> Nebraska | <input type="checkbox"/> Utah |
| <input type="checkbox"/> Hawaii | <input type="checkbox"/> Nevada | <input type="checkbox"/> Vermont |
| <input type="checkbox"/> Idaho | <input type="checkbox"/> New Hampshire | <input type="checkbox"/> Virginia |
| <input type="checkbox"/> Illinois | <input type="checkbox"/> New Jersey | <input type="checkbox"/> Washington |
| <input type="checkbox"/> Indiana | <input type="checkbox"/> New Mexico | <input type="checkbox"/> West Virginia |
| <input type="checkbox"/> Iowa | <input type="checkbox"/> New York | <input type="checkbox"/> Wisconsin |
| <input type="checkbox"/> Kansas | <input type="checkbox"/> North Carolina | <input type="checkbox"/> Wyoming |

10. NMDP Recipient ID (RID): _____

11. Zip or postal code for place of recipient's residence (USA recipients only): _____ - _____ (last 4 digits optional)

12. Specify blood type (recipient) **(For allogeneic HCTs only)** A B AB O

13. Specify Rh factor (recipient) **(For allogeneic HCTs only)** Positive Negative

14. Has the recipient signed an IRB / ethics committee (or similar body) approved consent form for submitting research data to the NMDP / CIBMTR?

- Yes (recipient consented) →
- No (recipient declined)
- Not approached

15. Did the recipient give permission to be directly contacted by CIBMTR for future research?
 Yes (recipient provided permission) No (recipient declined)

16. Date form was signed: __ __ __ __ / __ __ / __ __
 YYYY MM DD

17. Has the recipient signed an IRB / ethics committee (or similar body) approved consent form to donate research blood samples to the NMDP / CIBMTR?

- Yes (recipient consented) →
- No (recipient declined)
- Not approached
- Not applicable
(center not participating)

18. Date form was signed: __ __ __ __ / __ __ / __ __
 YYYY MM DD

19. Did the recipient submit a research sample to the NMDP/CIBMTR repository?
(Related donors only)

- Yes →
- No

20. Research sample recipient ID:

21. Is the recipient participating in a clinical trial? (clinical trial sponsors that uses CIBMTR forms to capture outcomes data)

- Yes →
- No

22. Study Sponsor
- BMT-CTN - **Go to question 24**
 - RCI-BMT - **Go to question 24**
 - PIDTC - **Go to question 24**
 - USIDNET - **Go to question 25**
 - COG - **Go to question 25**
 - Other sponsor - **Go to question 23**

23. Specify other sponsor: _____
 - **Go to question 25**

24. Study ID Number: _____

25. Subject ID: _____

Copy questions 22-25 to report participation in more than one study.

Hematopoietic Cellular Transplant (HCT) and Cellular Therapy

26. Is a subsequent HCT planned as part of the overall treatment protocol (not as a reaction to post-HCT disease assessment)? **(For autologous HCTs only)**

- Yes →
- No

27. Specify subsequent HCT planned Autologous Allogeneic

28. Has the recipient ever had a prior HCT?

- Yes →
- No

29. Specify the number of prior HCTs: _____

30. Were all prior HCTs reported to the CIBMTR? Yes No Unknown

Copy and complete questions 31-34 to report all prior HCTs that have not yet been reported to the CIBMTR:

31. Date of the prior HCT: ____ / ____ / ____ Date estimated
YYYY MM DD

32. Was the prior HCT performed at a different institution?

- Yes →
- No

Specify the institution that performed the last HCT:

33. Name: _____

City: _____

State: _____

Country: _____

34. What was the HPC source for the prior HCT? (check all that apply)

- Autologous
- Allogeneic, unrelated donor
- Allogeneic, related donor

35. Reason for current HCT

- Graft failure / insufficient hematopoietic recovery - **Go to question 36**
- Persistent primary disease - **Go to question 40**
- Recurrent primary disease - **Go to question 37**
- Planned subsequent HCT, per protocol - **Go to question 40**
- New malignancy (including PTLD and EBV lymphoma) - **Go to question 38**
- Insufficient chimerism - **Go to question 40**
- Other - **Go to question 39**

36. Date of graft failure / rejection: ____ / ____ / ____
YYYY MM DD
- Go to question 40

37. Date of relapse: ____ / ____ / ____
YYYY MM DD
- Go to question 40

38. Date of secondary malignancy: ____ / ____ / ____
YYYY MM DD
- Go to question 40

39. Specify other reason: _____

40. Has the recipient ever had a prior cellular therapy? (do not include DLIs)

- Yes →
- No
- Unknown

41. Were all prior cellular therapies reported to the CIBMTR?

- Yes
- No →
- Unknown →

Copy and complete questions 42-45 to report all prior cellular therapies that have not yet been reported to the CIBMTR:

42. Date of the prior cellular therapy: __ __ / __ __ / __ __
YYYY MM DD

43. Was the cellular therapy performed at a different institution?

- Yes →
- No

44. Name: _____
 City: _____
 State: _____
 Country: _____

45. Specify the source(s) for the prior cellular therapy (check all that apply)

- Autologous
- Allogeneic, unrelated donor
- Allogeneic, related donor

Donor Information

46. Multiple donors?

- Yes →
- No

47. Specify number of donors: _____

To report more than one donor, copy questions 48-83 and complete for each donor.

48. Specify donor

- Autologous
- Allogeneic, related
- Allogeneic, unrelated

49. Specify product type (check all that apply)

- Bone marrow
- PBSC
- Single cord blood unit
- Other product →

50. Specify other product type: _____

51. Is the product genetically modified? **If autologous, go to question 80. If allogeneic related, go to question 52. If allogeneic unrelated, go to question 56.**

- Yes
- No

52. Specify the related donor type

- Syngeneic (monozygotic twin) - **Go to question 57**
- HLA-identical sibling (may include non-monozygotic twin) - **Go to question 57**
- HLA-matched other relative (does NOT include a haplo-identical donor) - **Go to question 53**
- HLA-mismatched relative - **Go to question 53**

53. Specify the biological relationship of the donor to the recipient

- Mother
- Father
- Child
- Sibling
- Fraternal twin
- Maternal aunt
- Maternal uncle
- Maternal cousin
- Paternal aunt
- Paternal uncle
- Paternal cousin
- Grandparent
- Grandchild
- Other biological relative

54. Specify other biological relative:

55. Degree of mismatch (related donor only)

- HLA-mismatched 1 allele - **Go to question 57**
- HLA-mismatched ≥ 2 alleles (does include haplo-identical donor) - **Go to question 57**

56. Specify unrelated donor type

- HLA matched unrelated
- HLA mismatched unrelated

57. Did NMDP/Be the Match facilitate the procurement, collections, or transportation of the product?

- Yes
- No

58. Was this donor used for any prior HCTs? (for this recipient)

- Yes
- No

59. NMDP cord blood unit ID: _____ - **Go to question 63**

60. NMDP donor ID: _____ - **Go to question 63**

61. Non-NMDP unrelated donor ID: (not applicable for related donors) _____
- **Go to question 63**

62. Non-NMDP cord blood unit ID: (include related and autologous CBUs) _____
- **Go to question 63**

63. Global Registration Identifier for Donors (GRID): _____

- NMDP cord blood unit, go to question 75**
- NMDP donor, go to question 75**
- Non-NMDP unrelated donor, go to question 66**
- Non-NMDP cord blood unit, go to question 64**

64. Is the CBU ID also the ISBT DIN number?

- Yes
- No
- Unknown

65. Specify the ISBT DIN number: _____

66. Registry or UCB Bank ID: _____ - **If 'Other registry' go to 67, otherwise go to question 68**

67. Specify other Registry or UCB Bank: _____

68. Date of birth (donor / infant)

Known →

69. Date of birth: (donor / infant) ____ / ____ / ____ - **Go to question 72**
 YYYY MM DD

Unknown

↳

70. Age (donor / infant)

Known →

Unknown

71. Age: (donor / infant) ____ Months (use only if less than 1 year old) Years

72. Sex (donor / infant)

Male Female

73. Specify blood type (donor) **(non-NMDP allogeneic donors only)**

A B AB O

74. Specify Rh factor (donor) **(non-NMDP allogeneic donors only)**

Positive Negative

75. Donor CMV-antibodies (IgG or Total) **(Allogeneic HCTs only)**

Reactive Non-reactive Indeterminant Not done Not applicable (cord blood unit)

76. Has the donor signed an IRB / ethics committee (or similar body) approved consent form to donate research blood samples to the NMDP / CIBMTR? **(Related donors only)**

Yes (donor consented) →

No (donor declined)

Not approached

Not applicable (center not participating)

77. Date form was signed: ____ / ____ / ____
 YYYY MM DD

78. Did the donor submit a research sample to the NMDP/CIBMTR repository? **(Related donors only)**

Yes →

No

79. Research sample donor ID:

80. Specify number of products infused from this donor: _____

81. Specify the number of these products intended to achieve hematopoietic engraftment: _____

Questions 82-83 are for autologous HCT recipients only. If other than autologous skip to question 84.

82. What agents were used to mobilize the autologous recipient for this HCT? (check all that apply)

- G-CSF (filgrastim, Neupogen)
- Pegylated G-CSF (pegfilgrastim, Neulasta)
- Plerixafor (Mozobil)
- Combined with chemotherapy
- Anti-CD20 (rituximab, Rituxan)
- Other agent →

83. Specify other agent: _____

To report more than one donor, copy questions 48-83 and complete for each donor.

Clinical Status of Recipient Prior to the Preparative Regimen (Conditioning)

84. What scale was used to determine the recipient's functional status?

 Karnofsky (recipient age \geq 16 years)**Performance score prior to the preparative regimen:**85. Karnofsky Scale (recipient age \geq 16 years)

- 100 Normal; no complaints; no evidence of disease
- 90 Able to carry on normal activity
- 80 Normal activity with effort
- 70 Cares for self; unable to carry on normal activity or to do active work
- 60 Requires occasional assistance but is able to care for most needs
- 50 Requires considerable assistance and frequent medical care
- 40 Disabled; requires special care and assistance
- 30 Severely disabled; hospitalization indicated, although death not imminent
- 20 Very sick; hospitalization necessary
- 10 Moribund; fatal process progressing rapidly.

 Lansky (recipient age \geq 1 year and $<$ 16 years)86. Lansky Scale (recipient age \geq 1 year and $<$ 16 years)

- 100 Fully active
- 90 Minor restriction in physically strenuous play
- 80 Restricted in strenuous play, tires more easily, otherwise active
- 70 Both greater restrictions of, and less time spent in, active play
- 60 Ambulatory up to 50% of time, limited active play with assistance/supervision
- 50 Considerable assistance required for any active play; fully able to engage in quiet play
- 40 Able to initiate quiet activities
- 30 Needs considerable assistance for quiet activity
- 20 Limited to very passive activity initiated by others (e.g., TV)
- 10 Completely disabled, not even passive play

87. Recipient CMV-antibodies (IgG or Total)

 Reactive Non-reactive Indeterminant Not done

Co-morbid Conditions

88. Is there a history of mechanical ventilation? Yes No
89. Is there a history of invasive fungal infection? Yes No

90. Glomerular filtration rate (GFR) before start of preparative regimen (**pediatric only**)

- Known →
- Unknown

91. Glomerular filtration rate (GFR): ___ ___ mL/min/1.73²

92. Does the recipient have known complex congenital heart disease (corrected or uncorrected)? (excluding simple ASD, VSD, or PDA repair) (**pediatric only**)

- Yes No

93. Were there any co-existing diseases or organ impairment present according to the HCT comorbidity index (HCT-CI)? Source: Sorrow, M. L. (2013). How I assess comorbidities before hematopoietic cell transplantation. Blood, 121(15), 2854-2863.

- Yes →
- No

94. Specify co-existing diseases or organ impairment (check all that apply)

- Arrhythmia – **Any history of atrial fibrillation or flutter, sick sinus syndrome, or ventricular arrhythmias requiring treatment**
- Cardiac – **Any history of coronary artery disease (one or more vessel-coronary artery stenosis requiring medical treatment, stent, or bypass graft), congestive heart failure, myocardial infarction, OR ejection fraction ≤ 50% on the most recent test**
- Cerebrovascular disease – **Any history of transient ischemic attack, subarachnoid hemorrhage or cerebral thrombosis, embolism, or hemorrhage**
- Diabetes – **Requiring treatment with insulin or oral hypoglycemic drugs in the last 4 weeks but not diet alone**
- Heart valve disease – **At least a moderate to severe degree of valve stenosis or insufficiency as determined by Echo; prosthetic mitral or aortic valve; or symptomatic mitral valve prolapse**
- Hepatic, mild – **bilirubin > upper limit of normal to 1.5 × upper limit of normal, or AST/ALT > upper limit of normal to 2.5 × upper limit of normal at the time of transplant OR any history of hepatitis B or hepatitis C infection**
- Hepatic, moderate/severe – **Liver cirrhosis, bilirubin > 1.5 × upper limit of normal, or AST/ALT > 2.5 × upper limit of normal**
- Infection – **Includes a documented infection, fever of unknown origin, or pulmonary nodules suspicious for fungal pneumonia or a positive PPD test requiring prophylaxis against tuberculosis. Patients must have started antimicrobial treatment before Day 0 with continuation of antimicrobial treatment after day 0**
- Inflammatory bowel disease – **Any history of Crohn's disease or ulcerative colitis requiring treatment**
- Obesity – **Patients older than 18 years with a body mass index (BMI) > 35 kg/m² prior to the start of conditioning or a BMI of the 95th percentile or higher for patients aged 18 years or younger**
- Peptic ulcer – **Any history of peptic (gastric or duodenal) ulcer confirmed by endoscopy or radiologic diagnosis requiring treatment**
- Psychiatric disturbance – **Presence of any mood (e.g., depression), anxiety, or other psychiatric disorder (e.g. bipolar disorder or schizophrenia) requiring continuous treatment in the last 4 weeks**
- Pulmonary, moderate – **Corrected diffusion capacity of carbon monoxide and/or FEV1 of 66-80% or dyspnea on slight activity attributed to pulmonary disease at transplant**
- Pulmonary, severe – **Corrected diffusion capacity of carbon monoxide and/or FEV1 of ≤ 65% or dyspnea at rest attributed to pulmonary disease or the need for intermittent or continuous oxygen during the 4 weeks prior to transplant**
- Renal, moderate / severe – **Serum creatinine > 2 mg/dL or > 177 μmol/L; on dialysis at during the 4 weeks prior to transplant; OR prior renal transplantation - Go to question 95**
- Rheumatologic – **Any history of a rheumatologic disease (e.g., systemic lupus erythematosus, rheumatoid arthritis, polymyositis, mixed connective tissue disease, or polymyalgia rheumatica, etc.) requiring treatment. (Do NOT include degenerative joint disease, osteoarthritis)**
- Prior malignancy, specify – **Treated at any time point in the patient's past history, other than the primary disease for which this infusion is being performed - go to question 96**

95. Was the recipient on dialysis immediately prior to start of preparative regimen?

- Yes No Unknown

96. Specify prior malignancy (check all that apply)

- Breast cancer
 Central nervous system (CNS) malignancy (e.g., glioblastoma, astrocytoma)
 Gastrointestinal malignancy (e.g., colon, rectum, stomach, pancreas, intestine, esophageal)
 Genitourinary malignancy (e.g., kidney, bladder, ovary, testicle, genitalia, uterus, cervix, prostate)
 Leukemia (includes acute or chronic leukemia)
 Lung cancer
 Lymphoma (includes Hodgkin & non-Hodgkin lymphoma)
 MDS / MPN
 Melanoma
 Multiple myeloma / plasma cell disorder (PCD)
 Oropharyngeal cancer (e.g., tongue, buccal mucosa)
 Sarcoma
 Thyroid cancer
 Other prior skin malignancy (basal cell, squamous) - Go to question 97
 Other prior hematologic malignancy - Go to question 98
 Other solid tumor - Go to question 99

97. Specify other prior skin malignancy: _____

98. Specify other prior hematologic malignancy: _____

99. Specify other solid tumor: _____

Use results within 4 weeks prior to the start of the preparative regimen, report results from the test performed closest to the start date. Biomarkers according to the augmented HCT comorbidity index Source: Biol Blood Marrow Transplant. 2015 Aug; 21(8): 1418-1424.

100. Serum ferritin (with 4 weeks prior to the start of the preparative regimen, use result closest to the start date)

- Known ->
 Unknown

101. _____ ng/mL (µg/L)

102. Date sample collected: ___ / ___ / ___
YYYY MM DD

103. Upper limit of normal for your institution: _____ ng/mL (µg/L)

104. Serum albumin (with 4 weeks prior to the start of the preparative regimen, use result closest to the start date)

- Known ->
 Unknown

105. _____ • _____ g/dL g/L

106. Date sample collected: ___ / ___ / ___
YYYY MM DD

107. Platelets (with 4 weeks prior to the start of the preparative regimen, use result closest to the start date)

Known →

Unknown

108. _____ x 10⁹/L (x 10³/mm³) x 10⁶/L

109. Were platelets transfused ≤ 7 days before date of test?

Yes No Unknown

110. Did the recipient have a prior solid organ transplant?

Yes →

No

111. Specify organ:

Bowel

Heart

Kidney(s)

Liver

Lung(s)

Pancreas

Other organ →

112. Specify other organ: _____

113. Year of prior solid organ transplant: _____

Copy and complete questions 111-113 for each prior solid organ transplant

Pre-HCT Preparative Regimen (Conditioning)

114. Height at initiation of pre-HCT preparative regimen: _____ inches centimeters

115. Actual weight at initiation of pre-HCT preparative regimen: _____ • _____ pounds kilograms

116. Was a pre-HCT preparative regimen prescribed?

Yes →

No - **Go to question 129**

117. Classify the recipient's prescribed preparative regimen (**Allogeneic HCTs only**)

Myeloablative Non-myeloablative (NST) Reduced intensity (RIC)

118. Was irradiation planned as part of the pre-HCT preparative regimen?

Yes →

No

119. What was the prescribed radiation field?

Total body

Total body by intensity-modulated radiation therapy (IMRT)

Total lymphoid or nodal regions

Thoracoabdominal region

120. Total prescribed dose: (dose per fraction x total number of fractions)

_____ • _____ Gy cGy

121. Date started: ____ / ____ / ____

 YYYY MM DD

122. Was the radiation fractionated?

Yes →

No

123. Total number of fractions: _____

Indicate the total prescribed cumulative dose for the preparative regimen:

124. Drug (choose from list)

- Bendamustine
 Busulfan
 Carboplatin
 Carmustine (BCNU)
 CCNU (Lomustine)
 Clofarabine (Clolar)
 Cyclophosphamide (Cytoxan)
 Cytarabine (Ara-C)
 Etoposide (VP-16, VePesid)
 Fludarabine
 Gemcitabine
 Ibritumomab tiuxetan (Zevalin)
 Ifosfamide
 Melphalan (L-Pam)
 Methylprednisolone (Solu-Medrol)
 Pentostatin
 Propylene glycol-free melphalan (Evomela)
 Rituximab (Rituxan)
 Thiotepa
 Tositumomab (Bexxar)
 Treosulfan
 Other drug

125. Specify other drug: _____

126. Total prescribed dose: _____ • _____

- mg/m²
 mg/kg
 AUC (mg x h/L)
 AUC (μmol x min/L)
 CSS (ng/mL)

127. Date started: ____ / ____ / ____
YYYY MM DD

128. Specify administration (busulfan only)

- Oral IV Both

Copy and complete question 124-128 to report each drug given for the preparative regimen

Additional drugs given in the Peri-Transplant period

129. ALG, ALS, ATG, ATS

- Yes →
 No

130. Total prescribed dose: _____ mg/kg

131. Specify source

- ATGAM (horse)
 ATG – Fresenius (rabbit)
 Thymoglobulin (rabbit)
 Other →

132. Specify other source: _____

133. Alemtuzumab (Campath)

- Yes →
 No

134. Total prescribed dose: _____ • mg/m² mg/kg mg

135. Defibrotide

Yes No

136. KGF

Yes No

137. Ursodiol

Yes No

GVHD Prophylaxis

This section is to be completed for allogeneic HCTs only; autologous HCTs continue with question 141

138. Was GVHD prophylaxis planned?

- Yes →
 No

139. Specify drugs / intervention (check all that apply)

- Abatacept
 Anti CD 25 (Zenapax, Daclizumab, AntiTAC)
 Blinded randomized trial
 Bortezomib
 CD34 enriched (CD34+ selection)
 Corticosteroids (systemic)
 Cyclosporine (CSA, Neoral, Sandimmune)
 Cyclophosphamide (Cytoxan)
 Extra-corporeal photopheresis (ECP)
 Ex-vivo T-cell depletion
 Filgotinib
 Maraviroc
 Methotrexate (MTX) (Amethopterin)
 Mycophenolate mofetil (MMF) (CellCept)
 Ruxolitinib
 Sirolimus (Rapamycin, Rapamune)
 Tocilizumab
 Tacrolimus (FK 506)
 Other agent →

140. Specify other agent: _____
 (do not report ATG, campath)

Post-HCT Disease Therapy Planned as of Day 0

141. Is additional post-HCT therapy planned?

- Yes →
- No - *Go to First Name*

Questions 142-143 are optional for non-U.S. centers

142. Specify post-HCT therapy planned (check all that apply)

- Azacytidine (Vidaza)
- Blinatumomab
- Bortezomib (Velcade)
- Bosutinib
- Brentuximab
- Carfilzomib
- Cellular therapy (e.g. DCI, DLI)
- Crenolanib
- Daratumumab
- Dasatinib
- Decitabine
- Elotuzumab
- Enasidenib
- Gilteritinib
- Ibrutinib
- Imatinib mesylate
- Intrathecal therapy (chemotherapy)
- Ivosidenib
- Ixazomib
- Lenalidomide (Revlimid)
- Lestaurtinib
- Local radiotherapy
- Midostaurin
- Nilotinib
- Obinutuzumab
- Pacritinib
- Ponatinib
- Quizartinib
- Rituximab (Rituxan, MabThera)
- Sorafenib
- Sunitinib
- Thalidomide (Thalomid)
- Other therapy →
- Unknown

143. Specify other therapy: _____

First Name: _____

Last Name: _____

E-mail address: _____

Date: __ __ __ __ / __ __ / __ __
YYYY MM DD